For State Use Only
Client ID# _____

MEDICAID APPLICATION
For Child with Adoption Assistance

Application Date: _____

Child (Applicant) and Adoptive Family Information

Child's Adopted Name (last, first, middle)	Social Security Number	Date of Birth (MM-DD-YYYY)
Current Address: (post office box & street, city, state, zip)		County
Adoptive Parent Name(s)		Telephone #

1. **Originating State:** In what State was the adoption assistance agreement established for the above named child?

   _____

   Effective dates of current adoption assistance agreement:

   From: _____ To: _____

2. **Adoption Finalization:** Has the adoption been finalized?

   ____ Yes Finalization Date: _____

   ____ No Expected Finalization Date: _____

3. **Ethnic Background:** What is the child's ethnic background? (Check One)

   ____ American Indian ____ Asian/Pacific Islander

   ____ Black/Non Hispanic ____ Hispanic

   ____ White/Non Hispanic ____ Other _____

4. **Identity:** Federal law now requires verification of the child's identity through documentary evidence. *(Identity must be verified with an original document. If child is under age 16 complete the attached Affidavit of Identity. If over age 16 the eligibility worker will need to see the original document for verification.)*

   ☐ Driver license ☐ State issued ID card

   ☐ School issued photo ID card ☐ Affidavit of Identity

5. Citizenship: Is the child a U.S. citizen? Federal law now requires verification of the child's citizenship through documentary evidence.

____ Yes

Has birth certificate been amended?

____ Yes *(Attach amended birth certificate.)*
____ No *(Send amended birth certificate as soon as available.)*

____ No Date of entry into U.S. _____
(Attach copy of INS card. Send amended birth certificate as soon as available.)

Are the parents of the child U.S. citizens?
Mother _____ Yes _____ No
Father _____ Yes _____ No

6. Social Security Number: Have you applied for a name change with the Social Security Administration on the Social Security Number for the child?

____ Yes Social Security Number listed above is the SS#. The name has been changed.

(Attach a copy of Social Security card with name change.)

____ No Have not requested a name change for the above SS#.
(Send a copy of Social Security card with name change as soon as available.)

7. Student Status: Is the child a student?

____ Yes School: _____ District: _____

Full time student? ____ Yes ____ No

____ No Describe Reason: _____

8. Disability:
Is the child blind? ____ Yes ____ No
Is the child disabled? ____ Yes ____ No
Is the child receiving Supplemental Security Income (SSI)? ____ Yes ____ No

9. Health Insurance: Is the child covered by any health insurance through the child's (adoptive) parents or stepparents?

____ Yes If yes, please provide the following:

Insurance Company Name: _____

Insurance Company Phone: _____

Name of Policy Holder: _____

Policy #: _____ Effective Start Date: _____

____ No

10. **Accident:** Has the child been injured in an accident or assault for which the child is or will be receiving medical treatment?

____ Yes If yes, please provide the following:

Name of Injured Party: _____

Name of Liable Party:: _____

Name and Phone # of Attorney: _____

Brief Description of Injury: _____

_____

____ No

11. Other Responsible Party: Is any other person providing medical insurance for the child?

____ Yes If yes, please provide the following:

Insurance Company Name: _____

Insurance Company Phone: _____

Name of Policy Holder: _____

Policy #: _____ Effective Start Date: _____

____ No

12. Major Medical Need: Does the child have both a major medical need (such as cancer, AIDS, diabetes, heart disease, ALS, or pregnancy) and either (1) Insurance available that the parents have not purchased, or (2) Insurance that has terminated within the past 60 days?

____ Yes If yes, please provide the following:

Insurance Company Name: _____

Insurance Company Phone: _____

Name of Policy Holder: _____

Policy #: _____ Effective Start Date: _____

____ No

13. If insurance was available, but was not obtained for the child, please indicate reason below. (*Note: You are not obligated to include the adoptive child on your policy, but if available, Medicaid may purchase a separate policy for the child from the provider as part of the child's Medicaid coverage. This will not affect your family's coverage.)*

- ☐ Premiums or deductibles are too high.
- ☐ Concern that family coverage will reach maximum.
- ☐ Medical condition will require excessive out of pocket expense.
- ☐ Other *(please describe)* _____

Before You Sign This Application, Please Ensure You Understand the Information Below.
If you have any questions, please ask the eligibility worker.

I verify that the child for whom this application is submitted is a U.S. citizen or an alien in lawful immigration status. The Division of Child and Family Services will verify reported alien registration numbers with the Immigration and Naturalization Service (INS). The Division will not report undocumented household members to INS.

The medical assistance program rules will be followed for this child. If the child receives medical assistance that s/he is not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the child named on the medical card to use the medical card.

If the Utah Department of Health pays for the child's medical care, I assign to the Department rights to payments from any third party and to benefits for medical services. I will give to the Department any money I collect from an insurance policy or from someone required to pay for the child's medical expenses. I authorize payment directly to the Department of Health or the Office of Recovery Services and will hold harmless any party making payment to them. I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family.

I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the Utah Department of Health has written. I understand the medical benefits my child is eligible to receive through Medicaid may be changed without my knowledge or consent.

I authorize any person or organization to release medical records or information about my child to the Department of Health, Division of Health Care Financing or designee. The Department of Health, the Department of Work Force Services, and the Department of Human Services may give health care providers information about my child's eligibility for medical assistance.

I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My child's medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

I (print name) _____ read or had read to me the statements on this page. I understand those statements. I am a parent who is legally responsible for the child for whom this application is submitted. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

_____

Signature Date

For State Use Only
State Originating Adoption Assistance: _____ Adoption Assistance Eligibility: IV-E State
ICAMA: Yes No ICPC: Yes No Utah Medicaid Eligibility: SA/F SA/C SA/D SA/B

Eligibility Worker: *Date:* *Pacmis #*

Affidavit of Identity of Minor Child / Children

DATE:_____

Child's Name	Date of Birth	Place of Birth	Case Number

Under penalty of perjury, I declare that each child named above, who is under the age of 16, for whom I have applied for Medicaid / CHIP benefits is the same individual for whom birth verification has been provided.

_____ _____

Adult Signature Relationship

_____ _____

Witness* Title/Relationship

*Witness only required if adult signature is an "X", or by mark.

Your Rights and Responsibilities

You have the right to:

- Apply or reapply any time you wish for any medical program offered by the Department of Health. Another person may help you apply if you need help.

- Know why we approved or denied your application and the reasons for the decision. For medical assistance, we must give you a decision within 30 days or 90 days if you claim to be disabled unless you need more time.

- Know if we reduce, stop, or hold your assistance and why. In most cases, we will tell you 10 days before we do.

- Do the following things if you do not agree with decisions regarding your case:

  A. Talk to your eligibility worker. Make sure you are not misunderstanding each other.
  B. Talk to your worker's supervisor.
  C. Talk to Constituent Services. This telephone number is 538-6417 or call toll-free 1-877-291-5583.
  D. Request a Fair Hearing with an impartial Hearing Examiner.
  E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden call 394-9431. In Salt Lake, call 328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.

- Look at the information collected by the Division of Child and Family Services about your child's case. Information about your child and your child's case is confidential. The information may be given to other agencies if they need information to administer the program to help your child.

Your Responsibilities:

Verify Information: You must provide the Social Security number for your child who is applying for medical assistance. If you do not have a number, you must prove you have applied. Your child may be eligible for assistance while s/he is waiting to receive a number. Giving us your child's Social Security Number is required under the Social Security Act.

Your child's Social Security number will be used with the State Income and Eligibility Verification System (an electronic match system) to make sure that your child is eligible for federal assistance programs. Computer matching, program reviews, and audits may be done with Job Service, Immigration and Naturalization, Social Security, and Internal Revenue Service records. We may also do inquiries to any other organizations that may have eligibility information about your child. Computer checks will be done when you apply after you receive assistance. You must give us proofs to show that your child is eligible for assistance. If you do not understand what we need or you cannot give us the proof we are asking for, talk to your eligibility worker.

Cooperate: You must cooperate in any review of your case by Quality Control, Recovery Services, the Bureau of Eligibility Review, and the Division of Child and Family Services. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a "good cause" claim. Your worker can explain this procedure. You must report changes in your circumstances.

Changes You Must Report:

Remember that you are required to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can effect the amount of your child's benefits or your child's eligibility. If you receive more than you are eligible to receive, you will have to repay that amount.

Cancellation of Adoption Assistance Agreement
Immediately report to the eligibility worker if your child's adoption assistance agreement is discontinued for any reason (such as failure to renew or the child turns 18, gets married, or joins the military).

No Longer Providing Support for the Child
Notify the subsidy technician and eligibility worker if you are no longer providing any type of financial support for the child.

You Are Moving to a New Location
Notify the subsidy technician and eligibility worker if you are moving to a new location within Utah or outside of Utah.

Change in Insurance Coverage
Notify the eligibility worker of changes in access to insurance coverage or enrollment in any health coverage plan for the child and of any accidents or injuries which may be payable by a third party.

Eligibility Worker Name: _____ Phone #: _____

UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 04/14/2003

The Utah Department of Health, Division of Health Care Financing (DHCF) is committed to protecting your medical information. DHCF is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

CONFIDENTIALITY PRACTICES AND USES

DHCF may use your health information for conducting our business. Examples:

Treatment - to appropriately determine approvals or denials of your medical treatment. For example, DHCF health care professionals who may review your treatment plan by your health care provider for medical necessity if a Medicaid recipient or for program listed services if a Primary Care Network (PCN) recipient.

Payment - to determine your eligibility in the Medicaid or PCN program and make payment to your health care provider. For example, your health care provider may send claims for payment to DHCF for medical services provided to you, if appropriate.

Health Care Operations - to evaluate the performance of a health plan or a health care provider. For example, DHCF contracts with consultants who review the records of hospitals and other organizations to determine the quality of care you received.

Informational Purposes - to give you helpful information such as health plan choices, program benefit updates, free medical exams and consumer protection information.

YOUR INDIVIDUAL RIGHTS

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *
- Request corrections or additions to your health information. *
- Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the Medicaid/DHCF or PCN Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid and PCN programs and the following:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices
- To protect victims of abuse, neglect, or domestic violence
- For health oversight activities such as investigations, audits, and inspections

- For lawsuits and similar proceedings
- When otherwise required by law
- When requested by law enforcement as required by law or court order
- To coroners, medical examiners, and funeral directors
- For organ and tissue donation
- For research approved by our review process under strict federal guidelines
- To reduce or prevent a serious threat to public health and safety
- For workers' compensation or other similar programs if you are injured at work
- For specialized government functions such as intelligence and national security

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

DHCF is required by law to:

- Maintain the privacy of your health information
- Provide this notice that describes the ways we may use and share your health information
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in DHCF offices and on our website, http://health.utah.gov/hipaa. You may also request a copy of any notice from your Medicaid/DHCF or PCN Privacy Officer listed below:

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, Medicaid recipients should contact the DHCF Privacy Officer, Craig Devashrayee, 801-538-6641; 288 North 1460 West, 3rd Floor, PO Box 143102, Salt Lake City, Utah 84114-3102; cdevashrayee@utah.gov.

Primary Care Network (PCN) recipients should contact the PCN Privacy Officer, Gayleen Henderson, 801-538-6135; 288 North 1460 West, 4th Floor, PO Box 144102, Salt Lake City, UT 84114-4102; ghenderson@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint.

You may also file a written complaint with the Office of Civil Rights, 200 Independence Avenue, S. W. Room 509F HHH Bldg., Washington, DC 20201